VIGPODER™ Prescription and Enrollment Form

PYROS™ TOTAL CARE

Instructions: FILL OUT and FAX completed form and attachments to 1-855-813-2039.
Call 1-888-760-8330 if you have any questions regarding this form or to contact Pyros Total Care.

1. PATIENT

Please select one: Newly prescribed Patient Patient currently on vigabatrin

Last Name First Name Preferred Language Gender M F

Home Address City State Zip

DOB Weight (kg) Height Date of Measurement

Parent/Guardian Relation to Patient

Home ( ) – Work ( ) – Mobile ( ) –

Parent/Guardian Phone (Please check preferred)

Phone ( ) – Okay to leave voicemail YES NO

Emergency Contact

2. INSURANCE *(PLEASE ATTACH COPIES OF FRONT AND BACK OF ALL MEDICAL AND PRESCRIPTION INSURANCE CARDS AS PART OF YOUR FAX)*

Medical Plan Name	Prescription Card Name	Secondary Insurance Plan Name
Member #	Phone #	Member #
Group #	Member #	Group #
Policy holder name	Group #	Policy holder name
Relationship to policy holder		Relationship to policy holder

3. PRESCRIBER

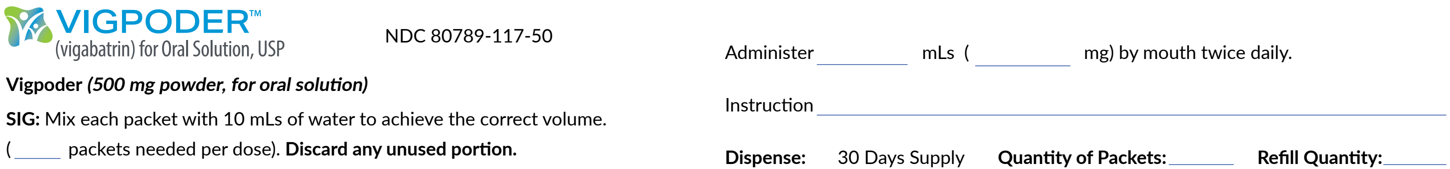
Prescriber Name/Title NPI State License #

Facility Name Address City State Zip

Office Contact Name Phone # Fax #

Contact's Email Preferred Contact Method: Phone Email Fax

4. PRESCRIPTION



VIGPODER™ (vigabatrin) for Oral Solution, USP

NDC 80789-117-50

Vigpoder *(500 mg powder, for oral solution)*

SIG: Mix each packet with 10 mLs of water to achieve the correct volume.
(_____ packets needed per dose). **Discard any unused portion.**

Administer _______ mLs (_______ mg) by mouth twice daily.

Instruction ____________________

Dispense: 30 Days Supply **Quantity of Packets:**_______ **Refill Quantity:**_______

5. DIAGNOSIS *(PLEASE INCLUDE COPIES OF CLINICAL NOTES)*

Please provide the following information:

- G40.821, Epileptic spasms, not intractable, with status epilepticus
- G40.822, Epileptic spasms, not intractable, w/o status epilepticus
- G40.823, Epileptic spasms, intractable, with status epilepticus
- G40.824, Epileptic spasms, intractable, w/o status epilepticus
- G40.82, Epileptic spasms, Salaam attacks; West's Syndrome
- G40.209 Local-related symptomatic epilepsy w/complex partial seizure, not intractable, w/o status epilepticus
- Other ICD-10: ____________________

Allergies

I hereby certify that I am prescribing the above medication for the named patient, and I affirm that the therapy described above is medically necessary based on my professional judgment.

Dispense Written
(Live Signature Required—Stamped Signatures Are Not Valid)

Substitution Allowed
(Live Signature Required—Stamped Signatures Are Not Valid)

Date Written

6. PATIENT AUTHORIZATION

Please attach separate Patient Authorization as part of your fax.

If the parent/guardian is not present to sign the Patient Authorization, direct them to *PTCConsent.com* to sign electronically.

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PYROS™
TOTAL CARE

Patient Authorization

Patient Name

Date of Birth

Protected Health Information

Pyros Pharmaceuticals, Inc., (“Pyros”) may provide useful patient information or updates about pharmacy services and other offerings. Pyros and its affiliates may contact me through email, direct mail, telephone, or text messaging (SMS). I understand that my wireless service provider’s message and data rates apply. I agree that Pyros may contact me for the purpose of soliciting my opinions on products, programs, and services. Pyros respects your personal information. However, I understand that my information, once disclosed under this authorization, may no longer be protected by state or federal privacy laws, and could be further disclosed. We encourage you to read our Privacy Notice at www.pyrospharma.com/privacy-policy.

Text Messaging

Anovo Pharmacy would like your permission to send you important pharmacy information regarding the patient’s prescription via text message (SMS). These notifications will not be marketing communications about your medication and will not include Protected Health Information. Providing authorization to receive text message notifications from Anovo is voluntary and is not required to receive pharmacy services from Anovo. I understand that text messages will be sent to the cellular phone number provided and you have the authority to request messages to be sent to the cellular phone number. I understand that my wireless service provider’s message and data rates apply.

Disclosure/Opt-Out

I understand that I have the option to decline signing this Authorization, and my access to treatment is not dependent on signing it. I understand that I am entitled to a signed copy of this Authorization. I understand that I may cancel this Authorization at any time by calling 1-888-760-8330 or by mailing a letter requesting such cancellation to AnovoRx Group, LLC, 1710 Shelby Oaks Dr., Ste 1, Memphis, TN 38134, which will convey the cancellation to any companies working with Pyros that have received the Authorization. I also understand that any such cancellation will not apply to any information already used or disclosed based on this Authorization before receipt of the cancellation by Pyros. This Authorization expires ten (10) years from the date signed below.

Please check the box(es) below to confirm acknowledgement and consent:

I acknowledge and grant authorization for Pyros Pharmaceuticals to use and disclose my Personal Health Information to third parties for the purposes stated in the Protected Health Information section in this document.

I acknowledge and grant authorization to Anovo Pharmacy to enroll me in the text messaging program to receive updates regarding the patient’s prescription as stated in the Text Messaging section of this document.

Patient/Guardian Signature

Date

Patient/Guardian Print Name

Cell #

Email Address

Mailing Address

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